# I-Resolutions Inc.

**An Independent Review Organization**
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**DATE NOTICE SENT TO ALL PARTIES:** Oct/12/2015

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:** dual spinal cord stimulator under fluoroscopy with IV sedation

**A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:** MD, Board Certified Anesthesiologist
MD, Board Certified Pain Medicine

**REVIEW OUTCOME:** Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

[ X ] Upheld (Agree)
[ ] Overturned (Disagree)
[ ] Partially Overturned (Agree in part/Disagree in part)

**Provide a description of the review outcome that clearly states whether medical necessity exists for <u>each</u> health care service in dispute.** It is the opinion of this reviewer that the request for dual spinal cord stimulator under fluoroscopy with IV sedation is not medically necessary

**PATIENT CLINICAL HISTORY [SUMMARY]: Patient is an** individual. On xxxxx, he was seen. At that time he had a complaint of chronic persistent right knee burning pain associated with swelling, temperature changes, and sensitivity to touch. On exam, he had reduced range of motion with 20-80 degrees of flexion with reproduction of his pain. On 05/21/15, he underwent a presurgical psychological evaluation for the proposed surgery. It was noted he was an appropriate candidate for the proposed spinal cord stimulator. On 07/23/15, the patient returned to clinic. It was noted he had a diagnosis of CRPS and met the Hardin criteria for that diagnosis. There was no evidence of substance abuse. A spinal cord stimulator was recommended.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION:** On 07/06/15, a peer review report noted the requested spinal cord stimulator was not medically necessary, as there is an absence of documentation noting that the patient met the criteria for a diagnosis of CRPS or even what criteria were used to make the diagnosis. Therefore the request was non-certified. On 08/21/15, a peer review noted the patient had undergone 4 surgeries and had findings of CRPS, for which the treatment was suggested, and the recent psychological evaluation noted severe depression and moderate anxiety and until those issues were addressed, the treatment would not be approved as those underlying psychological issues may be deleterious to his success.

Guidelines indicate that for this procedure, there should be a psychosocial evaluation addressing confounding issues. While the records indicate the patient has been cleared for the surgery, his confounding issues have not been addressed adequately. Therefore it is the opinion of this reviewer that the request for dual spinal cord stimulator under fluoroscopy with IV sedation is not medically necessary and the prior denials are upheld.

**A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:**

**[ ] ACOEM-AMERICA COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE**

**[ ] AHCPR-AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES**

**[ ] DWC-DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES**

**[ ] EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN**

**[ ] INTERQUAL CRITERIA**

**[ X ] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**

**[ ] MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**

**[ ] MILLIMAN CARE GUIDELINES**

**[ X ] ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**

**[ ] PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR**

**[ ] TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS**

**[ ] TEXAS TACADA GUIDELINES**

**[ ] TMF SCREENING CRITERIA MANUAL**

**[ ] PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**

**[ ] OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**